		FOR OHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036194

Facility Name: O'Fallon Health Care

Address: 700 Weber Drive (Number) O'Fallon (City) 62269 (Zip Code)

County: St. Clair

Telephone Number: (618) 632-3511 **Fax #** (618) 632-3053

IDPA ID Number: 37-1263590

Date of Initial License for Current Owners: May 31, 1990

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Deborah J Edwards **Telephone Number:** (618) 233-1001

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from Jan 1, 2005 to Dec 31, 2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) J. Michael Greer
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Deborah J Edwards, CPA
(Firm Name & Address) Creason-Edwards & Cimarolli, 4000 North Belt West, Belleville, IL 62226
(Telephone) (618) 233-1001 Fax # (618) 233-6009

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3	41	Intermediate (ICF)	41	14,965	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	145	TOTALS	145	52,925	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	116		4,754	4,870	8
9	SNF/PED					9
10	ICF	18,601	8,201		26,802	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,717	8,201	4,754	31,672	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 59.84%

D. How many bed-hold days during this year were paid by the Department?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started JUNE 1, 1990

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date MAY 31, 1990 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 104 and days of care provided 4,870

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: Dec 31, 2005 Fiscal Year: Dec 31, 2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number O'Fallon Health Care # 0036194 **Report Period Beginning:** Jan 1, 2005 **Ending:** Dec 31, 2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	304,649	29,232	6,722	340,603		340,603		340,603			1
2	Food Purchase		215,441		215,441		215,441	(3,953)	211,488			2
3	Housekeeping	70,819	16,590		87,409		87,409		87,409			3
4	Laundry	60,439	18,849		79,288		79,288		79,288			4
5	Heat and Other Utilities			135,096	135,096		135,096		135,096			5
6	Maintenance	56,193	45,788	23,705	125,686		125,686		125,686			6
7	Other (specify):*											7
8	**TOTAL General Services**	492,100	325,900	165,523	983,523		983,523	(3,953)	979,570			8
	B. Health Care and Programs											
9	Medical Director			12,000	12,000		12,000		12,000			9
10	Nursing and Medical Records	1,357,692	86,579	2,825	1,447,096		1,447,096		1,447,096			10
10a	Therapy			849,448	849,448		849,448		849,448			10a
11	Activities	51,102	4,291	2,310	57,703		57,704		57,704			11
12	Social Services	38,867		12,219	51,086		51,086		51,086			12
13	CNA Training											13
14	Program Transportation			6,015	6,015		6,015		6,015			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,447,661	90,870	884,817	2,423,348		2,423,349		2,423,349			16
	C. General Administration											
17	Administrative	57,785	6,272	64,000	128,057	386	128,443	(14,542)	113,901			17
18	Directors Fees											18
19	Professional Services			22,692	22,692		22,692	1,375	24,067			19
20	Dues, Fees, Subscriptions & Promotions			54,016	54,016	(386)	53,630	(15,389)	38,241			20
21	Clerical & General Office Expenses	104,290	30,891	12,973	148,154		148,154	8,813	156,967			21
22	Employee Benefits & Payroll Taxes			336,913	336,913		336,913	4,127	341,040			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,703	3,703		3,703		3,703			24
25	Other Admin. Staff Transportation			2,463	2,463		2,463		2,463			25
26	Insurance-Prop.Liab.Malpractice			98,433	98,433		98,433		98,433			26
27	Other (specify):*			81,398	81,398		81,398	(66,568)	14,830			27
28	**TOTAL General Administration**	162,075	37,163	676,591	875,829		875,829	(82,184)	793,645			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,101,836	453,933	1,726,931	4,282,700		4,282,701	(86,137)	4,196,564			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number O'Fallon Health Care #0036194 **Report Period Beginning:** Jan 1, 2005 **Ending:** Dec 31, 2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			66,124	66,124		66,124		66,124			30
31	Amortization of Pre-Op. & Org.			805	805		805		805			31
32	Interest			88,820	88,820		88,820	(1,517)	87,303			32
33	Real Estate Taxes			42,579	42,579		42,579	3,276	45,855			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,015	2,015		2,015		2,015			35
36	Other (specify):*			41,201	41,201		41,201		41,201			36
37	**TOTAL Ownership**			241,544	241,544		241,544	1,759	243,303			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		120,522		120,522		120,522		120,522			39
40	Barber and Beauty Shops		6,391		6,391		6,391		6,391			40
41	Coffee and Gift Shops		5,802		5,802		5,802		5,802			41
42	Provider Participation Fee			79,388	79,388		79,388		79,388			42
43	Other (specify):*			33,190	33,190		33,190	(33,190)				43
44	**TOTAL Special Cost Centers**		132,715	112,578	245,293		245,293	(33,190)	212,103			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,101,836	586,648	2,081,053	4,769,537		4,769,538	(117,568)	4,651,970			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,917)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,517)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,036)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(33,190)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(63,231)	27		24
25	Fund Raising, Advertising and Promotional	(14,866)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,337)	27		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(523)	20		28
29	Other-Attach Schedule	3,276	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (117,341)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(227)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (227)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (117,568)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

O'Fallon Health Care

ID# 0036194

Report Period Beginning: Jan 1, 2005

Ending: Dec 31, 2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Property tax	$ 3,276	33	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	3,276		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number O'Fallon Health Care # 0036194 **Report Period Beginning:** Jan 1, 2005 **Ending:** Dec 31, 2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,953)	0	0	0	0	0	0	0	0	0	0	(3,953)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,953)	0	0	0	0	0	0	0	0	0	0	(3,953)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(14,542)	0	0	0	0	0	0	0	0	0	(14,542)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,375	0	0	0	0	0	0	0	0	0	1,375	19
20	Fees, Subscriptions & Promotions	(15,389)	0	0	0	0	0	0	0	0	0	0	(15,389)	20
21	Clerical & General Office Expenses	0	8,813	0	0	0	0	0	0	0	0	0	8,813	21
22	Employee Benefits & Payroll Taxes	0	4,127	0	0	0	0	0	0	0	0	0	4,127	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(66,568)	0	0	0	0	0	0	0	0	0	0	(66,568)	27
28	**TOTAL General Administration**	(81,957)	(227)	0	0	0	0	0	0	0	0	0	(82,184)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(85,910)	(227)	0	0	0	0	0	0	0	0	0	(86,137)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number O'Fallon Health Care # 0036194 **Report Period Beginning:** Jan 1, 2005 **Ending:** Dec 31, 2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,517)	0	0	0	0	0	0	0	0	0	0	(1,517)	32
33	Real Estate Taxes	3,276	0	0	0	0	0	0	0	0	0	0	3,276	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,759	0	0	0	0	0	0	0	0	0	0	1,759	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(33,190)	0	0	0	0	0	0	0	0	0	0	(33,190)	43
44	**TOTAL Special Cost Centers**	(33,190)	0	0	0	0	0	0	0	0	0	0	(33,190)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(117,341)	(227)	0	0	0	0	0	0	0	0	0	(117,568)	45

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Michael Geer	100%	O'Fallon Healthcare Center, Inc	O'Fallon			
Michael Geer	25%	Clinton Manor	New Baden			
Michael & Gail Geer	50%	St. Ann's	Chester			
Michael Geer	100%			Greer Management	Carlyle	Management

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fee	$ 64,000	Greer Management		$	$ (64,000)	1
2	V	17	Administrative Wages		Greer Management		49,458	49,458	2
3	V	22	Payroll Taxes		Greer Management		4,127	4,127	3
4	V	19	Accounting		Greer Management		1,375	1,375	4
5	V	21	Office Expenses		Greer Management		8,813	8,813	5
6	V				Greer Management				6
7	V				Greer Management				7
8	V				Greer Management				8
9	V				Greer Management				9
10	V				Greer Management				10
11	V				Greer Management				11
12	V				Greer Management				12
13	V								13
14	Total			$ 64,000			$ 63,773	$ * (227)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Greer Management	President	Management					Mgmt Contract	64,000	17,3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 64,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: ec 31, 2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$ #DIV/0!	1
2									#DIV/0!	2
3									#DIV/0!	3
4									#DIV/0!	4
5									#DIV/0!	5
6									#DIV/0!	6
7									#DIV/0!	7
8									#DIV/0!	8
9									#DIV/0!	9
10									#DIV/0!	10
11									#DIV/0!	11
12									#DIV/0!	12
13									#DIV/0!	13
14									#DIV/0!	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ #DIV/0!	25

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Bank of Illinios		X	Mortgage	$9,541.00	11/13/2001	$ 1,000,000	$ 778,487	11/20/2006	Variable	$ 42,142	1
2	First National Bank		X	Vehicle	$448.00	7/30/2004	14,850	8,539	8/15/2007	4.9900	551	2
3	Greer Management Svc Inc	X		Operating		1/31/2005	90,000	80,000		5.0000	8,075	3
4	Michael Greer	X		Operating		1/1/1992	295,000	150,000		5.0000	9,875	4
5	See Attached Schedule						409,000	409,000			20,450	5
	Working Capital											
6	First National Bank		X	S/T Working Cap Loan	$8,636.00	2/11/2005	95,000	8,636	1/11/2006	5.5000	2,766	6
7	First Bank		X	Line Of Credit			160,000			Variable	4,946	7
8	First National Bank		X	S/T Working Cap Loan	$8,375.00	2/11/2004	92,125		1/11/2005	4.0000	15	8
9	TOTAL Facility Related				$27,000.00		$ 2,155,975	$ 1,434,662			$ 88,820	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,155,975	$ 1,434,662			$ 88,820	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number O'Fallon Health Care **#** 0036194 **Report Period Beginning:** Jan 1, 2005 **Ending:** Dec 31, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	36,027	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	39,303	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,276	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	39,303	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	42,579	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	32,047	8
	2001	32,518	9
	2002	34,085	10
	2003	36,027	11
	2004	39,303	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME O'Fallon Health Care COUNTY St. Clair

FACILITY IDPH LICENSE NUMBER 0036194

CONTACT PERSON REGARDING THIS REPORT Deborah J Edwards

TELEPHONE (618) 233-1001 FAX #: (618) 233-6009

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-32.0-200-063	700 Weber Dr	$ 39,303.00	$ 39,303.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 39,303.00	$ 39,303.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 48,179 B. General Construction Type: Exterior Brick Frame Wood/Steel Number of Stories

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	493,476	1990	$ 25,000	1
2					2
3	TOTALS	493,476		$ 25,000	3

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	145		1990	1968	$ 1,070,706	$ 27,778	36	$ 27,778	$	$ 503,583	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Garage Building			1990	6,115		10			6,115	9
10	Building Improvements			1990	53,147	2,657	20	2,657		40,754	10
11	Painting			1991	29,153		7			29,153	11
12	Building Improvements			1991	18,498		8			18,498	12
13	Building Improvements			1991	12,908	645	20	645		9,590	13
14	Building Equipment			1991	15,936	797	20	797		10,314	14
15	Land Improvements			1992	17,531		10			17,531	15
16	Building Exterior			1992	20,000	1,000	20	1,000		13,087	16
17	New Roof			1992	20,700	1,035	20	1,035		13,718	17
18	Building Improvements			1993	20,648	1,032	20	1,032		12,565	18
19	Building Improvements			1994	4,418		10			4,418	19
20	Wall Covering			1995	16,310	803	10	803		16,310	20
21	Painting			1995	3,875	191	10	191		3,876	21
22	Signs			1996	4,537		7			4,537	22
23	Paved Lot			1997	7,182	718	10	718		6,044	23
24	Asphalt Improvement			1994	7,873		7			7,873	24
25	Building Improvements			1992	5,442	272	20	272		3,539	25
26	A/C Unit			1999	2,490	356	39	356		2,312	26
27	Walk in Coooler			1999	12,277	1,754	7	1,754		10,816	27
28	Ice Machine			1999	2,442	349	7	349		2,151	28
29	Sewer			2000	24,688	1,234	20	1,234		6,377	29
30											30
31	Boiler			2001	25,412	652	39	652		3,258	31
32	Plumbing			2001	4,613	118	39	118		542	32
33	1st Wing Renovations (Decorating, Flooring, Fixtures)			2001	34,288	879	39	879		4,029	33
34	Laundry Room Renovations			2001	10,581	271	39	271		1,243	34
35	Property Landscaping			2001	931	24	39	24		110	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Flatwork-Concrete Dumpster Pad	2002	$ 4,862	$ 125	39	$ 125	$	$ 395	37
38	Compressor Replacement on Chiller	2003	19,586	1,306	15	1,306		3,156	38
39	Alzheimer's Wing Remodeling	2003	91,340	3,654	25	3,654		9,134	39
40	Fire Alarm Panel	2003	2,878	192	15	192		400	40
41	Shower Rooms	2004	15,356	768	20	768		1,152	41
42	Nurses Stations	2004	7,700	513	15	513		770	42
43	Flooring	2004	20,451	4,090	5	4,090		6,135	43
44	Furniture	2004	2,289	229	10	229		343	44
45	Building Front door/windows	2004	4,289	110	39	110		165	45
46	Nurses Stations	2005	3,400	170	15	170		170	46
47	Smoke Detectors	2005	1,700	40	7	40		40	47
48	Flooring	2005	9,107	152	5	152		152	48
49	Remodel Rooms	2005	2,614	65	20	65		65	49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,638,273	$ 53,979		$ 53,979	$	$ 774,420	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 568,952	$ 6,888	$ 6,888	$		$ 557,922	71
72	Current Year Purchases	6,504	564	564		5	564	72
73	Fully Depreciated Assets	(83,479)					(83,374)	73
74								74
75	TOTALS	$ 491,977	$ 7,452	$ 7,452	$		$ 475,112	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	04 Dodge Van	2004	$ 17,786	$ 1,136	$ 1,136	$	5	$ 13,633	76
77	Facility	90 Med Van	2000	13,633	3,557	3,557		5	5,039	77
78										78
79										79
80	TOTALS			$ 31,419	$ 4,693	$ 4,693	$		$ 18,672	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,186,669	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 66,124	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 66,124	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,268,204	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☒ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2006	$
13.	12/31/2007	$
14.	12/31/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 2,015 Description: Copier
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				120,522		120,522	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$ 120,522		$ 120,522	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number O'Fallon Health Care # 0036194 **Report Period Beginning:** Jan 1, 2005 **Ending:** Dec 31, 2005

XV. BALANCE SHEET - Unrestricted Operating Fund. As of Dec 31, 2005 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 23,532	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 95,876)	1,058,238		3
4	Supply Inventory (priced at)	34,570		4
5	Short-Term Investments			5
6	Prepaid Insurance	26,305		6
7	Other Prepaid Expenses	1,001		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	1,867		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,145,513	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	1,000,000		14
15	Leasehold Improvements, at Historical Cost	567,568		15
16	Equipment, at Historical Cost	523,396		16
17	Accumulated Depreciation (book methods)	(1,197,499)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Deposits			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 918,465	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,063,978	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 208,842	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	123,920		30
31	Accrued Taxes Payable (excluding real estate taxes)	12,293		31
32	Accrued Real Estate Taxes(Sch.IX-B)	39,303		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 384,358	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	99,136		39
40	Mortgage Payable	778,487		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due Stockholder	559,000		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,436,623	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,820,981	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 242,997	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,063,978	$	48

***(See instructions.)**

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 22,674	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	(555)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 22,119	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	220,878	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Transfer of Assets to Owners**		15
16	Other (describe) **Forgave Long Term Debt**		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 220,878	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 242,997	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,216,412	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,216,412	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	747,878	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 747,878	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	4,809	12
13	Barber and Beauty Care	6,544	13
14	Non-Patient Meals	1,917	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 13,270	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,517	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,517	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	11,340	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 11,340	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,990,417	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	983,524	31
32	Health Care	2,423,350	32
33	General Administration	875,829	33
	B. Capital Expense		
34	Ownership	241,545	34
	C. Ancillary Expense		
35	Special Cost Centers	165,906	35
36	Provider Participation Fee	79,388	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,769,542	40
41	**Income before Income Taxes (line 30 minus line 40)****	220,875	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 220,875	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,405	1,490	$ 43,837	$ 29.42	1
2	Assistant Director of Nursing	1,841	2,085	36,534	17.52	2
3	Registered Nurses	22,720	22,870	435,140	19.03	3
4	Licensed Practical Nurses	3,699	4,980	91,629	18.40	4
5	CNAs & Orderlies	65,720	69,398	719,944	10.37	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,929	2,145	27,215	12.69	9
10	Activity Assistants	3,334	3,517	23,887	6.79	10
11	Social Service Workers	2,918	3,086	38,867	12.59	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,008	2,168	36,282	16.74	14
15	Cook Helpers/Assistants	33,126	34,776	268,367	7.72	15
16	Dishwashers					16
17	Maintenance Workers	4,840	4,946	56,193	11.36	17
18	Housekeepers	9,521	9,895	70,819	7.16	18
19	Laundry	7,171	7,514	60,439	8.04	19
20	Administrator	1,720	2,045	57,785	28.26	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,302	8,801	104,290	12.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,176	2,246	30,608	14.00	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	172,430	181,962	$ 2,101,836 *	$ 11.55	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	168	$ 6,722	1,3	35
36	Medical Director	64	12,000	9,3	36
37	Medical Records Consultant	100	1,000	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	97	1,825	10,3	39
40	Physical Therapy Consultant	5,224	333,760	10a.3	40
41	Occupational Therapy Consultant	4,727	301,481	10a'3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3,786	214,207	10a,3	43
44	Activity Consultant	42	2,310	11,3	44
45	Social Service Consultant	51	2,811	12,3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	14,259	$ 876,116		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Linda Simmons	Administrator		$ 57,785
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 57,785

B. Administrative - Other

Description	Amount
Greer Management	$ 64,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 64,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Creason-Edwards & Associates	Acconting	$ 13,150
Bev Froemling	Accounting	1,000
Giffin, Winning	Legal	2,827
Van Ostrand & Elvidge Kelley	Legal	90
Ivans	Billing Services	1,371
WDM Computer Service Inc	Data Processing	2,855
Accu-Med Services	Computer Support	1,164
Home Pharmacy	Computer Support	235
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 22,692

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 75,856
Unemployment Compensation Insurance	62,934
FICA Taxes	158,432
Employee Health Insurance	39,691
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Payroll Taxes Greer Management	4,127
TOTAL (agree to Schedule V, line 22, col.8)	$ 341,040

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 995
Advertising: Employee Recruitment	35,061
Health Care Worker Background Check	
(Indicate # of checks performed 117)	1,170
Various Public Relations	14,866
Dues and Subscriptions	840
Yellow Pages	523
Employee Drug Testing	175
Less: Public Relations Expense	(14,866)
Non-allowable advertising	( )
Yellow page advertising	(523)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,241

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Out-of-State Seminar	
In-State Travel	390
Various In-State Seminars	3,313
Books	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,703

**See instructions.

Facility Name & ID Number O'Fallon Health Care # 0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number O'Fallon Health Care **#** 0036194 **Report Period Beginning:** Jan 1, 2005 **Ending:** Dec 31, 2005

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **685** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **79,388**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

O'FALLON HEALTHCARE CENTER INC.
#0036194
Period Jan 1, 2005 to Dec 31, 2005

RECLASSIFICATION SCHEDULE V

Line 17	$386
Line 20	($386)

Reclassify City/Misc License and Permits

SCHEDULE V, LINE 27, COL 3 - OTHER

Bad Debt Expense	$63,231
Employee Theft Loss	$14,830
Illinois Replacement Tax	$3,337
	$81,398

SCHEDULE V, 36, COL - OTHER

Loss on Sale of Fixed Assets	$41,201

SCHEDULE V, LINE 43 COL 3 - OTHER

Fines	$33,190

SCHEDULE XIII, A-1 - TYPE OF TRAINING PROGRAM

No aides were trained in 2005. The aides were already cerified when hired

STATE OF ILLINOIS

Facility Name & ID Number: O'Fallon Healthcare Center, Inc. #0036194 Report Period Beginning: Jan 1, 2005 Ending: Dec 31, 2005

Schedule IX. Line 5A

1 Mortgege or Note Holder			2 Related ** YES	2 Related ** NO	3 Purpose of Loan	4 Monthly Payment	5 Date of Note	6 Amount of Original	7 Amount of Balance	8 Maturity Date	9 Interest Rate (4 Digits)	10 Reporting Period Interest Expence
Michael Greer			X		Operating		8/31/2003	303,000	303,000		5.00%	15,150
Michael Greer			X		Operating		1/16/2004	41,000	41,000		5.00%	2,050
Michael Greer			X		Operating		5/31/2004	65,000	65,000		5.00%	3,250
Totals								409,000	409,000			20,450